

ANNEX G  
CURRENT STATUS  
OF  
MENTAL HEALTH ADVISORY TEAM (MHAT-I)  
ISSUES  
AND  
RECOMMENDATIONS  
OPERATION IRAQI FREEDOM (OIF-II)  
MENTAL HEALTH ADVISORY TEAM (MHAT-II)

30 January 2005

Chartered by:  
The U.S. Army Surgeon General

*This is an annex to the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report addressing the Behavioral Healthcare System in the OIF Theater of Operation (Kuwait and Iraq). The findings were obtained via direct observation, interviews, surveys, and data calls.*

The views expressed in this report are those of the authors and do not necessarily represent the official policy or position of the Department of Defense (DoD), the U.S. Army, or the Office of The Surgeon General (OTSG).

**ANNEX G**

**TABLE OF CONTENTS**

<b><u>INTRODUCTION</u></b> .....	<b>G-3</b>
<b><u>FINDINGS</u></b> .....	<b>G-4</b>
<b><u>DISCUSSION</u></b> .....	<b>G-12</b>

## **INTRODUCTION**

In December 2003, The Army Surgeon General's Mental Health Advisory Team (MHAT-I) identified a number of issues to improve behavioral health (BH) services throughout the Operation Iraqi Freedom (OIF-I) Theater. In August-October 2004, the MHAT-II collected data to evaluate the progress being made in addressing the OIF-I MHAT issues—both within the OIF Theater and in Germany/continental United States (CONUS). The MHAT-I recommendations are the starting point for discussing the issues, but this is not intended as an assessment of "compliance." The decision makers in OIF-II may have implemented other actions to fix an identified problem.

The data supporting the findings that follow this page were garnished from the OIF-I MHAT Report, portions of this (OIF-II MHAT) report, or were collected during the months of August through December 2004. Findings are summarized on the following pages. Sources of data for each finding listed below are located in various annexes of the MHAT-II Report. Status of MHAT-I issues as of December 2004 is described as GREEN, AMBER, or RED. GREEN indicates that substantial progress or completion has been achieved in addressing this issue based on data collected in MHAT-II. AMBER indicates that some significant progress has been achieved in addressing this issue. RED indicates that little or no progress has been made on this issue. Some issues were described as "Future"; therefore, it may be premature to expect progress to be made in only 1 year.

## **FINDINGS**

<b>OIF-I MHAT ISSUES</b>	<b>STATUS</b>	<b>OIF-II MHAT FINDING</b>
1. A. Appoint a Theater/Area of Operation BH consultant to advise the Surgeon on BH issues.	GREEN	Colonel (b)(6)-2 was appointed the OIF Theater/Area of Operation BH consultant and arrived in theater in April 2004.
1. B. Execute an aggressive BH outreach program. Ensure that BH personnel have a regular, far-forward consultation program at the small-unit level.	GREEN	Most Soldiers in the OIF-II Theater have access to BH resources, and 79% of BH professionals indicate they provided combat and operational stress control (COSC) outreach services once each week or more. Seventy-six percent of OIF-II Soldiers live on a Forward Operating Base (FOB) that has resident BH care. There are presently 232 BH personnel either present on site or visiting FOBs and sites where Soldiers are serving. Suggest continued evaluation of placement of resources in order to best meet the BH needs of the Soldiers in theater.
1. C. Area of responsibility (AOR) BH consultants need to distribute BH assets appropriately.	AMBER	Seventy-six percent of OIF-II Soldiers live on a FOB that has resident BH care. Some FOBs had no resident BH services but may be provided services presently by BH professionals from other FOBs. Some gaps remain. Operation Iraqi Freedom (OIF-II) BH planners implemented and are widely advertising a "Help 4 U" web site and a 24 hours/day telephone point of contact through which any leader or service member can learn how to contact the nearest providers to coordinate access.
1. D. Field a simple, standardized needs assessment tool for Soldiers and units.	AMBER	Walter Reed Army Institute of Research (WRAIR) has developed a needs assessment tool for use by BH personnel in theater that is ready for initial fielding. While BH personnel in theater conduct needs assessments, recommendation remains to field a standardized tool to allow for research opportunities, better communications between providers, etc.

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
1. E. Train Soldiers in meeting the demands of deployment/combat-related stressors.	AMBER	The MHAT-II Soldier Health and Well-being Survey data indicate Soldiers reported higher levels of training in handling the stresses of deployment compared with Soldiers in OIF-I. The Center for Health Promotion and Preventive Medicine (CHPPM) and MHAT developed five Tip Cards that were distributed by Multi-National Corps-Iraq (MNC-I) in October 2004 in spite of logistical problems. Efforts are underway to provide these cards and instructions to units for internal training before they leave CONUS or while in staging areas in Kuwait. Additional work needs to be done to standardize, implement, and assess training materials.
1. F. Improve the ability to hold Soldiers in theater closer to their own units. Create a BH Reconditioning Program.	GREEN	Operation Iraqi Freedom (OIF-II) Theater BH has increased the ability to hold Soldiers in theater and provide BH fitness teams to further assess patients. Restoration programs were found in (b)(2)-2. Soldier and staff reports and return-to-duty rates are favorable on these programs. There is no shortage of combat stress control (CSC) and medical company cots to hold Soldiers in theater during Restoration or Reconditioning. The table(s) of organization and equipment (TOE) capabilities of the CSC fitness teams now deployed were designed for stress casualty rates predicted in a major theater with possible use of weapons of mass destruction.
1. G. Improve the quality of behavioral healthcare services for Soldiers during evacuation.	GREEN	The quality of behavioral healthcare services for Soldiers during evacuation has improved based on revised standing operating procedures (SOPs), better command and control, and better transmission of clinical data from theater to Lanstuhl and from Lanstuhl to other medical treatment facilities (MTFs). In spite of these improvements, no specific BH initiatives have been developed.
2. A. Area of responsibility BH consultants should establish quarterly BH training meetings.	GREEN	Area of responsibility BH Consultant, Colonel (b)(6)-2 established a quarterly BH training meeting schedule; meetings took place 6 June 2004 and 15 September 2004. Attendance has been excellent with representatives of MNC-I staff, Multi-National Force-Iraq (MNF-I) staff, combat brigades, combat support hospitals (CSHs), CSC units, and division mental health (MH) staff.

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
2. B. Conduct COSC training for BH personnel, both Active Component/Reserve Component (AC/RC), preparing to deploy.	GREEN	<p>Training was conducted for all deploying CSC units during Calendar Year (CY) 2004. A team of COSC specialists from Medical Command (MEDCOM), Army Academy of Health Sciences (AHS), and Walter Reed Army Medical Center (WRAMC) provided COSC training to (b)(2)-2 CSC personnel during (b)(2)-2 at (b)(2)-2 to (b)(2)-2 CSC personnel during (b)(2)-2 to (b)(2)-2 CSC personnel in (b)(2)-2 and to pre-deploying Army National Guard (ARNG) MH personnel in (b)(2)-2. Future training for deploying units will be scheduled as units are alerted and preparing to deploy and COSC subject matter experts (SMEs) have been recruited to conduct training sessions as requirements are identified. Medical Command staff members are coordinating this effort presently.</p>
2. C. Conduct COSC research in key areas to ensure that the best prevention and early intervention methodologies are established/validated.	AMBER	<p>Walter Reed Army Institute of Research (WRAIR) has an approved research protocol to assess the validity of COSC critical event debriefing (CED) intervention methods. Implementation is scheduled for 2005. As of 26 October 2004, the Deputy Assistant Secretary of Defense for Clinical and Program Policy tasked the Armed Forces Epidemiological Board to explore further OIF mental health issues and support research activities. There was an initial planning session on 30 November and 1 December 2004 to examine future research questions involving all of the armed services. A multi-service cooperative effort should develop to further study combat stress issues.</p>
3. Plan for the upcoming battle-handover.	GREEN	<p>Planning sessions did take place at MEDCOM, and BH services and personnel were expanded in OIF-II to meet growing demands and OPTEMPO. Operation Iraqi Freedom (OIF-III) and -IV planning sessions took place at MEDCOM in November and December 2004. All redeploying and deploying division psychiatrists are in e-mail contact to improve turnover. (b)(2)-2</p>

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
4. A. Designate proponents to manage the Coalition Forces Land Component Command (CFLCC) and Coalition Joint Task Force-7 (CJTF-7) Suicide Prevention Programs.	AMBER	<b>The existing community-based Army Suicide Prevention Program has been adapted to OIF Soldiers and units. A survey of the brigades in theater revealed that all brigades identified a suicide prevention program in their AOR. They all indicated that they have a designated proponent to manage the suicide prevention program. MHAT-II learned that most Unit Ministry Teams (UMTs) have completed Applied Suicide Intervention Skills Training (ASIST), but more effort is required to ensure the Suicide Prevention Program is fully implemented during pre-deployment, deployment, and post- deployment.</b>
4. B. Maintain vigilance by leaders and Soldier-peers to ensure Soldiers at risk for suicide receive appropriate support.	GREEN	Soldiers who indicated they received adequate training in handling the stresses of deployment and/or combat in OIF-II reported significantly higher confidence in their ability to help Soldiers get assistance for a MH problem. Twenty-seven percent indicated they actually helped a fellow Soldier get professional help for a MH problem. Suicide rates in OIF-II are significantly lower than in OIF-I.
4. C. Conduct training that provides crisis intervention skills to designated Soldiers with a goal of one trained Soldier per company.	AMBER	Soldiers in OIF-II reported higher levels of training in handling the stresses of deployment compared with Soldiers in OIF-I. Crisis intervention skill training was conducted in the (b)(2)-2. The (b)(2)-2 CSC Unit began "in theater" training in October 2004. Plans to expand the training throughout theater are being explored. Response by combat divisions to the crisis intervention skills training thus far has been very positive.
4. D. Implement surveillance of completed suicides and serious suicide attempts with standardized suicide event reporting by BH personnel.	AMBER	The AMEDD Suicide Events Report (ASER) reporting process implemented with submissions on completed suicides for 2004. Serious suicide attempts reporting is not occurring consistently in theater presently. This requires emphasis by Office of The Surgeon General (OTSG) and Army Medical Department (AMEDD) commanders and staff.

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
<p>4. E. Establish a command climate that encourages appropriate help-seeking behavior by distressed Soldiers. Behavioral health care should be delivered as far forward as possible to maximize the likelihood of successfully returning Soldiers to duty.</p> <p><b><u>Future Implementation</u></b></p> <p>1. A. Direct The Surgeon General (TSG) BH consultants to develop and implement a multidisciplinary COSC course to teach COSC doctrine, tactics, and procedures to all BH/COSC personnel.</p> <p>1. B. Direct TSG behavioral health consultants to charter multidisciplinary PATs to develop the key elements for inclusion in the course.</p> <p>1. C. Direct TSG behavioral health consultants to reorient the AMEDD officer and enlisted military education systems to integrate collective blocks of instruction in COSC, disaster BH, and battlefield professional practice.</p> <p>1. D. Direct CHPPM and TSG behavioral health consultants to ensure that a COSC/BH track is incorporated into the annual Force Health Protection (FHP) Conference.</p>	<p>AMBER</p> <p>AMBER</p> <p>AMBER</p> <p>AMBER</p> <p>GREEN</p>	<p>The MHAT-II Soldier Health and Well-being Survey found that the percent of Soldiers with MH problems that accessed professional services increased from 29% in OIF-I to 40% in OIF-II. However, there were no appreciable differences between the perceptions that OIF-I Soldiers had compared with OIF-II Soldiers that they would be stigmatized by their unit or leadership if they received help. A review of BH staff located in theater indicated providers were far forward in most instances and the return-to-duty rate for those seen far forward was over 95% and over 90% by the division and brigade BH teams.</p> <p>Behavioral health consultants are developing a proposal for a CSC course presently that will provide training for all BH specialties with priority for those in COSC duty positions.</p> <p>Behavioral health consultants are developing a proposal for a CSC course presently.</p> <p>Behavioral health consultants are developing a proposal for a CSC course presently.</p> <p>A BH track was incorporated in the annual FHP Conference during 2003 and 2004 and is planned for 2005.</p>

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
2. A. Medical Command should review the COSC Workload and Activity Reporting System (COSC-WARS) for sufficiency and then automate it.	AMBER	The MH teams under MNC-I and the medical units under the Medical Brigade used the COSC-WARS Summary Report (SR), with hand entry of data. Problems were identified with standardization, training, and written instructions. The SR format needs to record additional variables. The COSC-WARS Preventive Contacts (PC) and Individual Contacts (IC) data entry formats (never used for routine manual entry) have been automated by CHPPM for data entry into handheld and laptop computers. A pre-pilot, debugging trial of the software and hardware began in October 2004 in two CSC units in Iraq. The CHPPM is incorporating lessons learned. Combat stress control units and MH sections mobilizing for OIF-III are receiving the software and training. With Command approval, a pilot test could be conducted in OIF-III.
2. B. Medical Command should integrate COSC prevention efforts into existing and emerging theater medical databases.	AMBER	The automated PC and IC programs will generate the periodic SRs, and can be programmed to generate the Disease/Nonbattle Injury (DNBI) Report and other report formats. The Army Medical Department Center and School (AMEDDC&S) and potential users are evaluating the integration of COSC-WARS and the Medical Communications for Combat Casualty Care (MC4) system. The COSC-WARS is the AMEDD Combat Developments and CHPPM test-bed for developing precise contract requirements for the COSC component of the totally automated Theater Medical Information Program of the Future Force.
3. Medical Command should establish a joint process action committee to work on an evacuation database system capable of clinical, tracking, and analytical functions. It must be readily available, secure, and tailored to the needs of line commanders, medical personnel, medical regulating planners, and medical planners.	RED	No effort to change the evacuation database has been put forth as of this time.

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
4. A. Develop a peer-mentoring program using mid-grade Soldiers to facilitate the early identification and intervention of psychosocial problems at the company level.	AMBER	<p>The WRAIR behavioral health staff has a proposal for this program and has presented it to the Deployment Cycle Support Program Manager and WRAIR for consideration and implementation. It has similarity to the British model focused on traumatic risk assessment and management. The (b)(2)-2 in OIF-II is testing an adaptation of the British Traumatic Risk Management (TRM) Program. A peer-mentoring training program, taught to noncommissioned officers (NCOs), has also been developed, and the (b)(2)-2 CSC Unit in Iraq is field testing it presently. No officially sanctioned peer-mentoring program has been approved or fielded as of now. Additional training for medics, battalion and company commanders, first sergeants (1SGs), and platoon leaders in stress management training and BH issues is recommended, with COSC personnel among the trainers. This will shore up the existing infrastructure rather than introduce a new program that line or medical leadership may not support.</p>
4. B. Improve BH support for rear-detachment commanders and Family Readiness Groups (FRGs). One possible solution would be to have social workers fulfill this mission.	AMBER	<p>Some AR, ARNG, and Army AC commands are now using Army Community Service (ACS) family program coordinators or social workers and in some cases activated Behavioral Health Officers (e.g. (b)(2)-2 Regional Readiness Command (RRC)) to assist families during pre-deployment, deployment, and post-deployment. In addition, Army One Source has been established to assist Soldiers or family members by referring them to local resources to address issues of concern and paying for six counseling sessions to help resolve issues of concern. The following other resources have been established to address BH support for rear-detachment commanders and FRGs:</p> <ul style="list-style-type: none"> <li>• Care Manager Program.</li> <li>• Disabled Soldiers Support System (DS3).</li> <li>• Extended TRICARE Benefits.</li> </ul> <p>The Army Deployment Cycle Support Program managers (DCSPER-G-1 staff) are presently exploring alternatives to ensure the referral and availability of needed services for Soldiers and family members. Medical Command will be involved in ensuring the successful implementation of BH support and was solicited in November 2004 to provide input to the DCSPER-G-1 staff to design the programs.</p>

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
<p>5. Implement monitoring of serious suicide attempts within Army medical surveillance systems. Task CHPPM and the BH consultants to develop capability for monitoring serious suicide attempts at the installation, operational, and Army-wide levels. The pilot version of the ASER is a promising tool for reporting suicide attempts.</p>	<p>AMBER</p>	<p>The ASERs for completed suicides for OIF have been submitted as required, and data have been compiled and distributed on these cases. The ASERs on suicide behaviors resulting in hospitalization and evacuation, but not death, have not been submitted consistently. Behavioral health leadership in theater must continue to emphasize submission to improve data collection rates.</p>

## **DRAFT**

### **DISCUSSION**

As is evident from the report above, many of the MHAT-I recommendations have been implemented in the past 12 months. More BH staff is present in theater in OIF-II. The overall ratio of BH personnel to Soldiers has increased from 1:846 in OIF-I to 1:407 in OIF-II. The number of BH personnel in theater now is sufficient to provide coverage throughout the OIF area of responsibility, a very great accomplishment.

As far as the 16 immediate recommendations from MHAT-I, there is evidence that 8, or 50%, have been fully implemented presently and that 8, or 50%, are at a minimum partially completed. Overall, 100% of MHAT-I recommendations have either been implemented fully or at least partially as of October 2004. This is a substantial step in meeting the needs of Soldiers in theater, and for this, staff should be commended.

As far as the 10 future recommendations from MHAT-I, 1 is fully implemented and 8 are partially implemented giving a total of 9 of 10 or 90% in place or in process. The other long-term recommendation should be the focus of efforts now in order to ensure the very best of care and outcomes for our Soldiers and their families in the future. Recommendations for action plans are developed in this report and will be emphasized to leadership. Without doubt, our Soldiers and their families will be well-served due to the extensive commitment and actions of BH staff and their actions on behalf of our force. All involved should be commended for their actions, and leadership should also be commended for their willingness to explore BH needs and the actions that have followed MHAT-I activities.